
'Dynamics of Change in the Public Service Sector: A Comparison of Working Conditions in French and German Hospitals'

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Karen Jaehrling, IAT, Gelsenkirchen, jaehr@iatge.de

Philippe Méhaut, LEST, Aix en Provence, mehaut@univ-aix.fr

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In most of the European countries, the changes of the employment relationship (Bosch, 2004) – or of the wage-earning relationship (Beffa, Boyer, Touffu, 1999) – remain on top of both the political and scientific debate. In countries such as France and Germany with highly regulated employment systems in the past (but based on different rules and actors), some politicians and social actors (namely employers associations) are claiming for more flexibility, deregulation, re-commodification of labour, transfer of the employment risks to the individual (Méhaut, 2004). Within the scientific community, questions arise about the nature and the pace of the change. Changes may affect the level, distribution and regulation of wages, the employment status, the work content and organisation etc. Hypothesis range from rather pessimistic perspectives observing a radical change (Beck, 2001, Castel, 2003) that results in a slow but continuous erosion of the past regulation. Other hypothesis are more towards small mechanic adjustments within the previous system or of an organic change which could result in new rules, but having respect to the main structural properties of the SER (Silvestre, 1989 for the concept, Bosch, 2004).

The paper is a very preliminary step to analyse and discuss theses questions in the specific field of the health care sector, in a comparative perspective between Germany and France. It is based on data and preliminary case studies gathered in the framework of the “Future of Low Wage Work in Europe” research, done in 5 European countries for the Russell Sage Foundation.

Focusing on the Hospital sector, and on low wage/low skilled occupations within the sector has advantages and difficulties. On the one hand, one can argue that the specificities of the sector (public activity, public regulations) are too high to arrive at conclusions on the process of change in the whole economy. But on the other hand, the health financing system and other recent developments exert similar pressures as in other industries and lead to similar reactions and changes in the competitive structures (**section 1**). And focusing on low level occupations allows us to escape (or to be at the margin) of the occupational and medical rules governing other occupations in the sector (such as doctors and nurses): it is the lowest segment of the hospitals labour force where hospitals compete on the labour market with other activities (cleaning, home personal care for example). A study of the low skill/low wage sector of the labour market also profits from the fact that this segment is often said to be more exposed to the change. Another advantage is that the high level of female employment in this industry is representative of one of the main changes within the employment structure, and of what is often regarded as the main deregulated (or at risk of deregulation) segment of the labour force. **Section 2** will investigate the various institutional rules, which characterized the previous employment system within hospitals. **Section 3** will present and discuss the main changes affecting the employment relationship and the way by which, in the two countries,

institutional frameworks are transformed, bypassed and/or unchanging. We will particularly compare wage levels and structures (3.1) and the proliferation of ‘atypical’ employment (3.2).

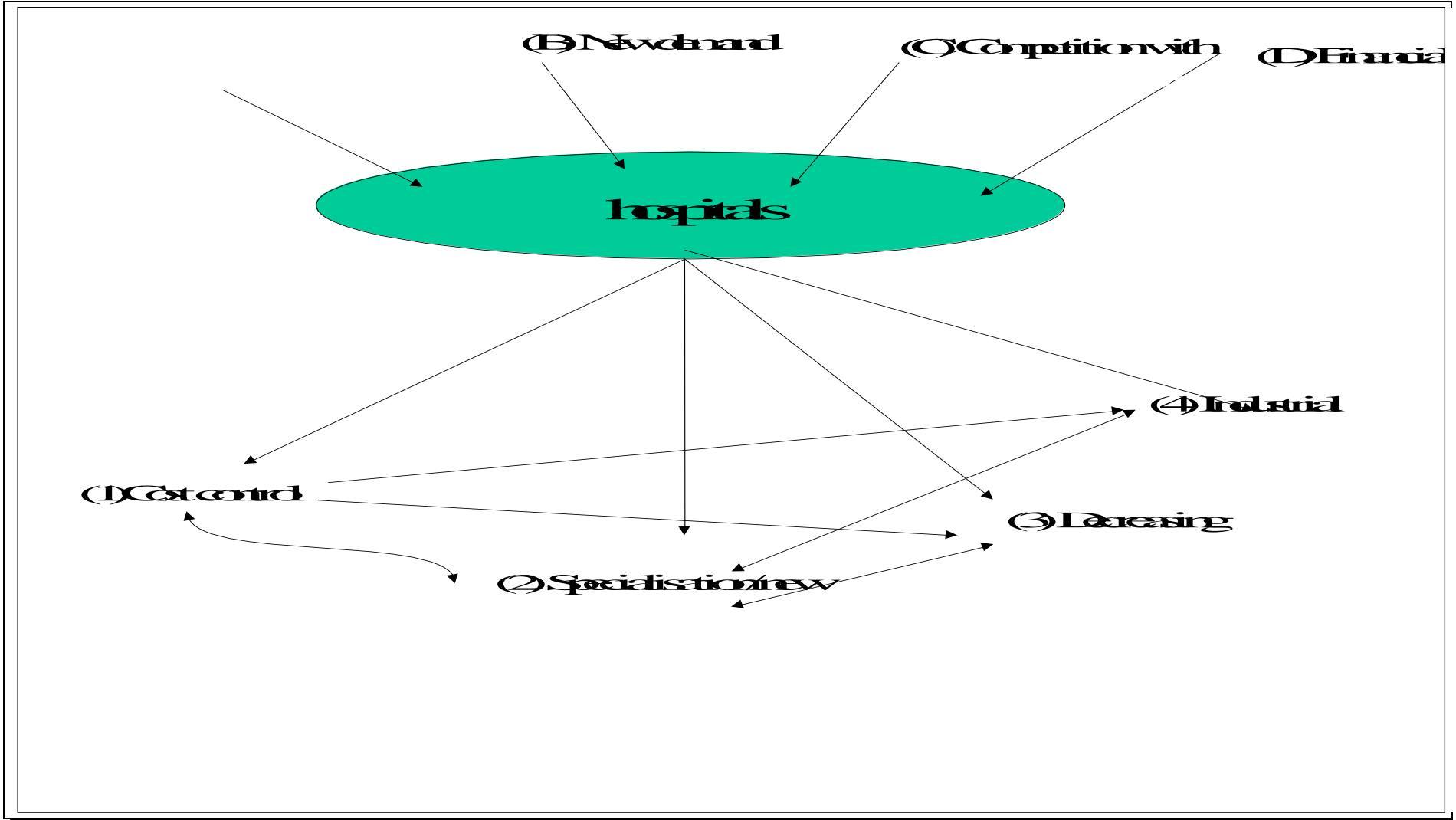
1. The hospital sector: from public sector to a “quasi-market” industry

Despite the high share of public and non profit structures, in both countries, hospitals are facing external pressures that are, by and large, functionally equivalent to the developments in the private sector. Since the early 1990s, the health sector in many European countries has developed into “quasi-markets” (cf. LeGrand/Bartlett 1993). This term denotes a changing relationship between provider and purchaser of services with the aim to create an ‘artificial market situation and increase efficiency - even though both sides may remain public, i.e. even when hospitals are owned by the same body (local authority, government) which is resourcing hospital expenditures. There are similar trends in other parts of the former public sector (transport, telecommunication, energy). In the hospital sector, this objective has been achieved mainly through a reform of the health financing systems. In addition to this, there have been further developments which affect the competitive structure of the sector.

1.1 The main pressures on the sector

The chart below provides a synthetic view of the main forces exerting high pressures on the hospitals in the two countries and some of the structural adaptations of the sector.

Graph 1 : pressures on the hospitals and ways of reaction



A) *Technological change*

The first pressure, which is internal to the hospitals, is the technicalisation of medical acts and the rapid development of “non-invasive” techniques. The latter translates – particularly in the field of surgery (but also in the field of medical diagnostic techniques) – into a reduction of the average duration of hospitalisation and into the development of “outpatient” hospitalisation.

B) *New demand for care*

In both countries, hospitals are facing new demands. On the one hand, in France, there is an increasing demand for emergency care, which is partly due to weaknesses in the non-hospital medical sector. It does not seem to be the case in Germany. In France, public hospitals are almost alone in providing comprehensive emergency care services, 24 hours a day. But some of these services are not necessarily followed by hospitalisation *stricto sensu* but rather by non-hospital treatment.

On the other hand, some complex diseases (AIDS), as well as the ageing (and the lengthening of life expectancy) of the population increase the demand for complex cares. Health care to elderly people, which amounts for an increasing part of health care expenditures, is partly provided through hospitalisation, and can contribute to increasing the average duration of hospital stays. But it is also provided by specialised structures (old age homes with medical care) that complement and/or compete with hospitals.

C) *Modification of the division of labour between hospitals and other health care providers.*

The main trends, both due to the patients’ demand and to the cost pressure are the development of home care facilities provided by various institutions and/or by liberal practitioners (liberal nurses in France) and of new specialised providers for long term stay and post hospitalisation care. Individualisation and customerisation of medical care is a common trend in the whole field of personal services.

D) *Financial pressure and external cost control*

In both countries, hospitals are facing dramatic changes. Hospitals are mainly funded by public funds and / or social insurance: 85% in Germany (and only 1,9% by private households), 90% in France (6% by households).

For a long time, in the two countries even under the control of different actors (the statutory health insurance scheme in Germany, more direct state control in France), public and private institutions were financed in the same way: the *per diem* reimbursement system (Mosse, 2004). A global budget was allowed to the hospital, usually on the base of the previous year budget, with *ex post* adjustment in case of deficit. But because it was considered as inflationary and incapable of reducing inequalities between hospitals, without enabling hospitals to reach objectives in terms of quality and efficiency¹, this technique of resource allocation was changed, in the eighties in France, at the beginning of the 1990s in Germany. Firstly a stricter control on the budget was applied, with “*a priori*” contracts with health authorities, secondly no settlement of deficits were allowed.

¹ But this question remains highly controversial within the scientific community

In a second step, flat rates have been introduced in place of daily rates following the example of the American DRGs: partly included in France as a way of modulation of the annual budgets since 1996, entirely since 2005 in Germany. And, in both countries, the system will evolve : uniform flat rates across all regions in Germany up to 2009, in the next ten years for France (but excluding some specific activities, such as research activity, emergency wards...).

The result is an increasing cost pressure on hospitals. As a matter of fact, in France, the annual rate of increase of hospitals expenditure was around 20% in the seventies, falling to 6% in the nineties and to 2% between 1996 and 2001 (Arborio et alii, 2005). In Germany between 1970 and 1985, the hospital expenditures rose from € 6 billion to € 26.2 billion (West Germany), and between 1991 and 2002 from € 42.8 to € 62 billion (Germany), thus the increase has considerably slowed down as well.

1.2 Reactions and changes in the competitive structure

In both countries, reactions to all these factors are very similar, but, as we will see in part 3 with different consequences on the employment relationship.

1. *External financial and cost control* lead to internal cost control and budgets cut : stricter management of the non medical costs (hotel costs, administrative costs), of the medical costs (choice of medical treatments), of the wage costs;
2. *Specialisation and development of new medical techniques* : it is partly a response to the technical change, but also to the cost control. Some hospitals are closing services, sharing high cost investment (such as scanner) between different hospitals (including sometimes some private/public partnership). In France, this process of rationalisation of the hospital map was conducted by a specific regional health authority. The aim is both to rationalise the supply of care and, through new techniques, to decrease the length of hospitalisation. It has probably an effect on the employment level and structure: increasing skills needs for doctors, nurses and other medical technicians
3. *Decrease of the length of hospitalisation*: as a consequence of the new techniques, but also of the demand from patient and of the cost control, the trend is to decrease as much as possible the length of stay : less invasive techniques, but also transfer of the patient to long stay medical houses and re-education houses as soon as possible. Hospitals could by this way cut the costs of housing which is not very profitable for us. From 1981 to 2000, the length of stay in medical, surgical and obstetric services decrease from 15 to 6.5 days in France. In Germany, for all hospital services, length of stay has decreased from 14 (1991) to 8.9 (2003) days. This process has various effects: on the one hand increasing work load and needs of doctors and nurses (as the short stay of patient means also more intensive care), but also for nurse assistant and or cleaning staff (as the quicker rotation of patients require more elementary nursing, and more cleaning of rooms) ; on the other hand, also a closer management of the beds, more administrative tasks.
4. *Industrial restructuring*. Here we can see common but also different trends between the two countries:
 - A common trend is the decreasing numbers of beds (which goes hand in hand with the more intense process of production) : -13% in ten years in France, -10% in Germany.

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- The merging of the hospitals, the closure of the smallest one's. This is particularly strong in the French private for profit sector, where the average number of beds per establishment increased from 70 to 84. As a consequence, among others, of the specialisation process, a change in the structure of the ownership. For France, the private for profit sector is more and more concentrated in surgical activities (44% of beds). Its weight remains high but decreases in obstetric (30% of beds). A new field of activity is expanding in medium term stay with 22% (Les établissements de santé, Dress, 2001). But, contrary to Germany, there is no process of privatisation of public hospitals, and the various form of private/public partnership are developing very slowly (only some isolated example of mixed structures, the most frequent case is the sharing of expansive equipments). In Germany the private for profit sector is increasing, both in general (acute care) hospitals and in more specialised hospitals (17% of the beds in 1994, 23% in 2002, but only 8% of beddays).
 - Subcontracting or transferring to private firms some activities. It is mainly the case for cleaning activities, linen cleaning, catering and some very specialized functions (informatics). In France, this is more often the case in private for profit hospitals, despite their small size. In public hospitals, the biggest ones are subcontracting some of these functions. But since the beginning of the century, a trend reversal can be observed: a decreasing percentage of the wage bill dedicated to subcontracts, reintegration of some tasks (cleaning of the patient rooms). The main reasons are one the one hand questions about the quality of the service (mainly the respect of hygienic norms), on the other hand the low evidence of costs cuts and, lastly, the specific regulations which obliged any subcontractor, when winning a bid, to reemploy the staff of the previous subcontractor. The trends towards outsourcing is more accentuated in Germany, even though there are no exact figures available. One indicator is the decrease of staff in housekeeping activities (cleaning etc) by 33% between 1991 and 2002. Similar to France, there seems to be a new trend towards an 'insourcing' of these activities, but only in a formal sense: after having outsourced their cleaning etc. to an external service provider, a part of the hospitals nowadays choses to set up their own service company and (re)integrate the cleaning staff in order to save the VAT. However, this insourcing is not necessarily accompagnied by better employment conditions since the service companies can offer employment conditions differing from those in the respective hospital itself.

All these constraints and trends are very similar to developments in the private sector.

2. The institutional framework of the “old” employment regulations

In both countries, the employment relationship was highly regulated by various rules and institutions and, despite the diversity of the ownership, there was some kind of homogenisation between public and private statutory rules. The common public funding and control were playing a similar role for all the hospitals..

2.1 Germany

The cost recovery principle, which applied until the early 1990s, had a powerful unifying effect on wages. The private non-profit owners usually adopted the collectively agreed wage structures and increases that had been agreed for the public hospitals. Wage negotiations in the public service are themselves very centralized: wages, wage groups, working time, holidays, etc. are negotiated at the central government level, with the employer side represented by an association of local authorities, the Verband kommunaler Arbeitgeberverbände (VKA),² and the employees represented by the Ver.di (Vereinigte Dienstleistungsgewerkschaft) trade union and an association of smaller trade unions, the dbb tarifunion, although this has far fewer members among public service employees. The two most important wage frameworks for the church hospitals (the AVR Diakonie and AVR Caritas, see below) used to be based on the public service wage framework. The guiding function of the public pay scale has, however, weakened under increasing cost pressure, as we will see in section 3.

The reason for this divergence can be found in the greater autonomy enjoyed by church employers in the matter of setting employment conditions. Here, wages and employment conditions are traditionally set within a process that the Churches call the “third way”, a middle path between unilateral prescription of wages and collective wage negotiations. Instead of unions, this process involves employee representatives from company-level staff representation bodies (“Mitarbeitervertretungen” – MAVs), the church equivalent of the works councils in secular businesses. As part of so-called labor law commissions (“Arbeitsrechtliche Kommissionen”), these staff representatives help formulate so-called employment contract guidelines (“Arbeitsvertrags-Richtlinien” - AVR), which are similar in content to collective agreements. If there is a dispute, however, the guidelines can be amended unilaterally by the employer side. For example, despite the resistance of the employee representatives, delegation clauses were unilaterally imposed for part of the hospitals of the Protestant Church’s social outreach ministry (Diakonisches Werk), which enabled the hospitals to reduce wages (cf. Ver.di Kirchen-Info 1/2004, p. 9ff, 14/15). At establishment level too, hospital managements face weaker negotiating partners than their counterparts in secular establishments. Because of a legal exemption for churches, instead of being governed by the works council constitution act (Betriebsverfassungsgesetz), they are governed by their own church laws, which grant the staff representation bodies fewer co-determination rights. Finally, a lower union density of union representatives is seen as an indicator for a generally lower mobilization capacity of employees in church establishments (cf. Interview 1). These institutional and corporate culture restrictions on the bargaining power of staff representatives have always been there, but used not to make themselves felt to such an extent. It is only in the altered financial circumstances that hospital managements and associations have increasingly started exploiting their options.

2.2 France

A clear distinction must be made between the public and private sectors. In the public sector, the vast majority of workers are civil servants. Public hospital workers are governed by the General Statute of the Civil Servants and by its article four that concerns the hospital civil service (since 1986). This statute defines the rules concerning recruitment, wages, mobility, work conditions, and trade union representation...(Derenne, Lucas, 2001). It is defined by law at national level and is compulsory for all public hospitals. Thus, for example, wage negotiations are held at national level and concern all civil servants (with the exception of

² Only a small minority of public hospitals, primarily the university clinics, is owned by the federal states or federal government and is therefore represented by them in wage negotiations. The negotiations are, however, held jointly with the VKA.

measures concerning specific categories). Therefore, in public hospitals there are no employers organisations with whom to negotiate. However they form an association (Federation of public hospitals) that serves as a representative of public hospitals to the political authorities, plays a consulting role and facilitates exchange between hospitals. This federation almost plays a role of “employers representative” in the different dual structures (for example within the national association of training which governs the funds for the training of public hospital staff). But we can say that a part of the civil servant rules are coming also from a kind of tripartite collective bargaining between the state, the Federation of public hospitals, and the unions. They usually discuss about all the topics (wage scale, corps specific regulations and advantages). At the turn of the century, big strikes (general public ones as well as specific strikes –nurses-) ended in a lot of “common protocols” to be later included in the civil servant status.

Wage control is driven by two sets of institutions. On the one hand, the minimum statutory wage for the private sector –SMIC- (defined by the law at the central level) is also playing a role for the public hospital sector, as the entry wage level of the lowest categories is sometimes below the SMIC. In this case, a specific premium is granted to the employees who are below the SMIC in the wage grid. On the other hand, since the mid of the nineties, and due to budget restrictions, the yearly and nationally defined for all the civil servant, wages’ rate of increase is often below the inflation rate, but not for the hospitals. Changes according to seniority and/or upgrading mobility are the only way to secure the purchasing power.

Private for profit hospitals are organised following the French model of industrial relations. A federation of employers (Federation of Private Hospitals, resulting from the merging of two federations that took place in 2001) organises and represents employers.

Both sub-groups compete with each other on the labour market. They also compete with non-hospital care institutions for the categories of workers we are discussing here. But given the weight and attractiveness of the civil service, the latter serves as reference. Thus in the new collective agreements of the private sector (2002) the parties represented in this negotiation have committed, through this agreement, to promote the social modernisation of private hospitals. The conventional mechanism shall serve as a basis for this social renovation but will only do so for the first stage of the process. Indeed, the parties intend to further improve the employees work conditions, *in the framework of a convergence of wage rates of public and private hospital employees*”. This new agreement was partly imposed by the public authorities : there was an opportunity for the private for profit sector to benefit from a special fund increasing the clinics’ resources. This opportunity has been linked in the bargaining with the public authorities to the settlement of a new common collective agreement.

3. Trends and changes of the employment relationship

We now examine, in both countries, what are the main trends for the lowest segment of the hospitals labour force.

3.1 Wage structure and wage levels

3.1.1 Germany: Different downward paths

In Germany, one of the main trends is wage cuts, either by modifying or by evading from the previous collective agreements framework. The ‘downward paths’ are differing according to

the ownership due to different institutional and organisational restraints. In the case of church owned hospitals, the employers have been able to achieve lower wage levels in their 'collective agreements' due to their greater freedom to unilaterally impose working conditions and due to the traditional weakness of unions in this sector. Wages for occupations in management services were lowered, so that entry-level wages in church hospitals are currently up to 25% below those paid in public hospitals (for cleaning staff e.g. € 7,62 /h entry wage in hospitals applying the 'collective agreement' of the Protestant Church Social Outreach Ministry (AVR Diakonie), compared to € 9,56/h (basic!) entry wage according to current collective agreement for public service).

However, the higher union density in local authority hospitals and the works council constitution act alone obviously offer only limited *long-term protection* against worsening employment conditions in the lower wage band. One area where this can be seen is in private hospitals that were previously owned by local authorities. Although the union often negotiates transition agreements for privatizations, which are designed to prevent job losses and any worsening of employment conditions by contract, a study commissioned by the Ver.di trade union finds that a common feature of the privatization cases studied is a greater wage spread, with doctors and qualified nurses tending to earn more and service staff and assistants less (cf. PLS Ramboll 2003: 5). The large hospital chains usually agree this in company-level wage agreements, although some do not have any wage agreements (ibid). The Ver.di trade union is generally concerned with concluding chain-wide wage agreements, but has so far had little success (cf. Interview 1). In addition, a number of other smaller establishments have merged to form regional associations of private hospitals, with which sector-level collective agreements have been signed, although these tend to set worse conditions than the company-level agreements of the large private clinic operators.

Even in the remaining local authority hospitals, continued commitment to the public service salary scheme (BAT / BMT-G) does not offer long term protection against wage cuts, only a different path. Since hospital managements are usually unable to withdraw from the BAT / BMT-G,³ they have made use of different strategies of 'bypassing' the traditional institutional setting characterizing the 'German Model', mainly by outsourcing some services (see also excursus x). This trend was probably given an extra boost in 1997 when the rule was abolished that stated that cost increases arising from collectively agreed wage increases were excluded from the budget cap⁴ Between 1991 and 2002 alone, the number of staff in housekeeping activities (cleaning etc) which were employed by the hospitals fell from 95.800 to 64.000 (FTE), thus decreased by 33%.⁵ As well as contracting out, hospitals have in recent years increasingly been setting up service companies, with the hospitals holding a majority interest in the companies. In such cases, hospital managements have demanded wage decreases of up to 30% (cf. Ver.di member magazine "*drei*" No. 11/2004: 6). Employees of external service companies as well as of service companies owned by the hospital itself usually earn much less than their colleagues directly employed by the hospitals. The wages according to the collective agreement for the cleaning industry are clearly below the low wage threshold (2/3 of median), which was at 1296 €/month (Eastern Germany) and 1709 €/month

³ This applies to the local authority hospitals under public law at least. Here, it is the local authorities, and not the hospital managements, which are members of the employers' association (VKA), so it would only be possible for the whole local authority to leave the association. A few local authorities in some Eastern German federal states have indeed left the VKA during the negotiations on the reform of the collective agreement, but they remain the exception.

⁴ Since that time, collectively agreed pay increases have been fully reimbursed only to the extent that they do not exceed the increase in earnings of the statutory health insurance schemes (cf. Löser-Priester 2003).

⁵ There is no reliable information available on how many of these 'direct' employees in public hospitals still come under the public service wage scale, since the above cited figure possibly also include employees of service companies owned by the hospitals themselves, with different wage conditions.

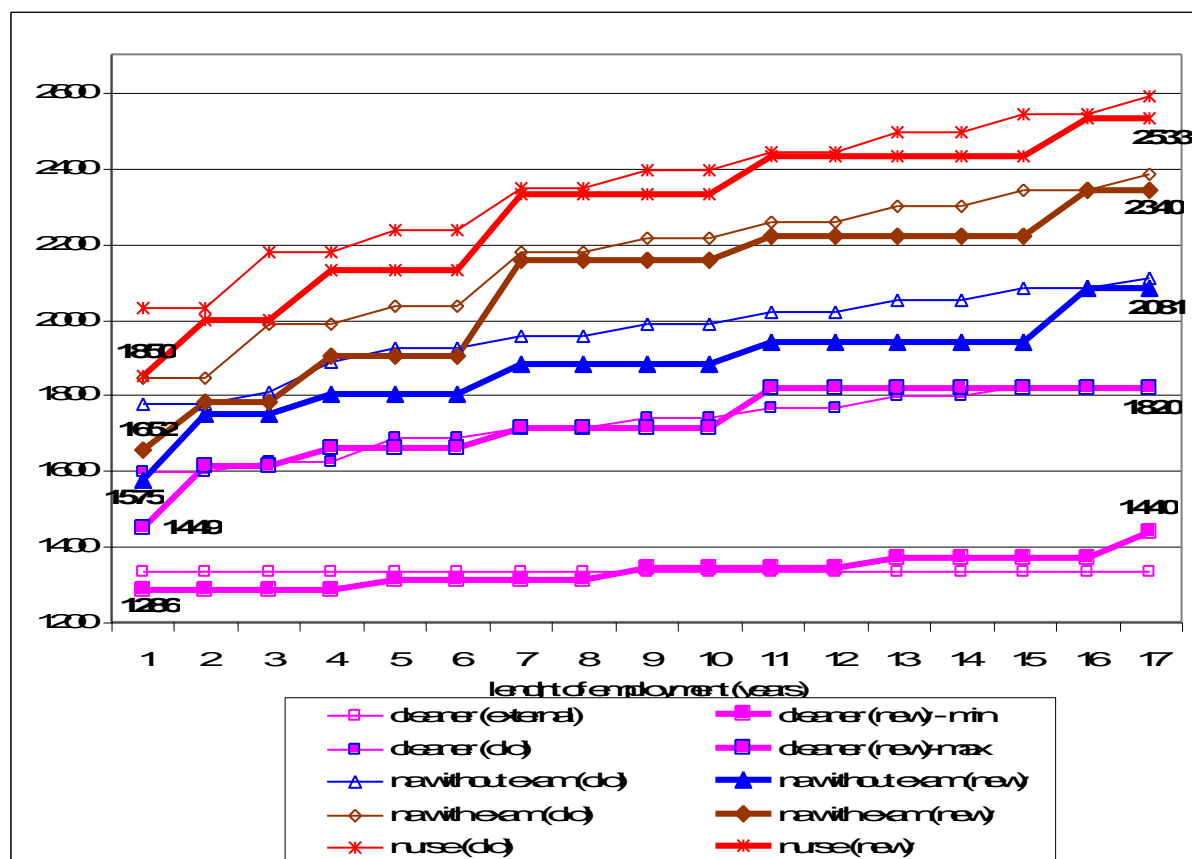
(Western Germany) in 2002. For the remaining direct employees in public hospitals, there is at present a rather low incidence of low wage work in our target occupations, due to the relatively high wages according to the current collective agreement.

However, this will change over the next decade, following a major reform of the public service sector collective agreement on wages. The reform was largely triggered by the lower wage scales of the private for profit and private non-profit providers of former public services. The employer's side wanted the remuneration of low skilled staff in housekeeping activities to be based on wages within the private industrial cleaning trade. The union side also signaled a willingness to accept corresponding decreases at an early stage in order to counteract the continuing flight from collective agreements through privatization and outsourcing in the service areas, and to obtain a sector-level wage scale (cf. Verdi 2004). Another central objective of the tariff reform was to reduce the wage increases by seniority in a neutral way, i.e. wage levels should be higher at entry level and lower at the end of the wages scale.

The new collective agreement will be effective from 1.10.2005. Surprisingly and contrary to the original intentions, the wage increases by seniority level have rather been increased, as the graph below shows, mainly due to a lowering of the entry wage levels – the differences between the first and the last step in the wage scale used to vary between 14% (cleaners) and 29% (nursing assistants), now it varies between 12% and 42%. The main changes in the target occupations seem to be a slight reduction in pay levels along the wage scale, and a strong reduction in a newly introduced low wage group. At € 1.286 per month (Eastern Germany: € 1.209), the entry wage level is even lower than the current wage for cleaning staff in the private cleaning industry, at least in the first years of employment. In view of the simultaneous axing of the family allowance the wages are also lower than the wages paid by some church hospitals. This new wage group will not automatically apply to all cleaners, but it is up to decentralized regional and company level collective bargaining which low-skilled occupation falls into this category.

Concerning wage differences among nursing staff, it also becomes clear that the new collective agreement does not thoroughly modify the wage differences between skill levels (as was hoped for from some employers): at the end of the wage scale, a regular nurse (without any specific task or personnel responsibility) for example earns 122% of the wage of a nursing assistant without exam, instead of 123% in the old tariff structure.

Graph 2: Basic monthly wages (in €) in target occupations according to current and future collective agreement for public sector (West Germany)⁶



Overall, for the occupations under study, at least for cleaning staff, this reform implies a sudden drop in wages to the lowest collectively agreed wage currently applicable in hospitals – with wages in the service companies and external service providers generally even lower. In practice, however, the introduction of the new low wage group will stretch over many years, since it only applies to new recruits. Moreover, since the field of application of the public wage framework has already shrunk considerably because of outsourcing, the drop in wages affects only a part of the housekeeping staff.

3.1.2 France : a rather stable figure

In the French public sector, the wage framework remains stable. As in Germany, seniority rules are important, but the difference between the first and last steps are higher.

⁶ In addition to the basic wages, there are several benefits and bonus payments which at least make up for an additional 10% of the wages and are often higher, depending on the number of children:

- holiday and christmas pay (roughly 10% of yearly income)
- child/family benefits (between 5% and 7% per child per month) – axed in the new collective agreement
- performance related payments, extra pay for extraordinary exposure (depending on occupation)
- extra pay for overtime
- additional employers contributions to supplementary company pension

For comparative purposes, the graph also shows the monthly wages of the cleaning staff in external service companies, according to the collective agreement for this industry. It shows that wages of the employees of external cleaning companies do not increase by seniority. There are also no further benefits or bonus payments for cleaners (except a supplementary company pension).

Table 1: Wage increases based on seniority (collectively agreed wages, 2005)

| | G (until 30.9.2005) | G (from 1.10.2005) | F (17-end) |
|---------------------|----------------------------|---------------------------|-------------------|
| Na with exam | 29% | 42% | 30%-50% |
| Cleaner* | 14% | 12-26% | 27%-40% |
| Nurse | 28% | 37% | 50%-80% |
| Nurse/NA ** | 108-110% | 108%-112% | 135%-160% |

* For France, the cleaners of the patient rooms in public hospitals (“agents des services hospitaliers”- ASH). ASH are also in charge of other tasks, as distributing the meals, helping to move patients...

** Wage difference between nurse and nurse assistant with exam

The relations between NA and ASH in the public sector point to issues of promotion from one position to the other. First of all, the wage evolution of NA placed in the lowest wage category is strictly identical to that of the first category of ASH. Second of all, the gap, on the wage grid, between category 2 ASH and NA in the lowest wage category is small (6 points initially, 11 points after 13 years, 21 points at the end of their career). Finally, the decree through which the posts of NA and ASH were created, stipulated that the number of ASH should not exceed one third of the number of NA. But this decree has never really been applied.

Since 1999, measures have been adopted to reduce the employment of non-civil service contract staff. Until 2002 the status of civil servant was granted to ASH who had been employed in the public sector for one year and who had been included the institution's aptitude list.

If we compare the trends between the public and private sectors (non for profit and for profit), from 1999 to 2002, (Collet, 2005, Brahami, Brizard, Audric, 2002) we see that :

- a) for the lowest categories (all hospitals) the wages' increase was of 9% (inflation rate 5.9%), with slightly the same trend for nurses;
- b) The wage gap with public hospitals (hourly net wages, controlled for age, gender, , full time), is -8.6% for the private non for profit hospitals and - 11.7% for the private for profit. This wage gap had decreased for the private for profit, but increased for the non for profit. If controlled also by occupations, between private for profit and public, it is higher for the lowest categories (-16%) than for the highest ones (-5% for nurses).

3.1.3 Incidence of low wage work

Looking now at low wage work, table 2 shows the incidence of low wage work in hospitals for the two countries. In Germany, in the whole health sector, the share of nursing assistants who were earning less than 2/3 of the median wage (West Germany: € 1709, East Germany: € 1296 gross monthly wage, corresponding to € 10,11 and € 7,67 gross hourly wage) was 21,6% in 2002; for the cleaning staff it was 42,6% (cf. Bosch/Kalina 2005, table 12). This shows that cleaners in the health sector are still better off than their colleagues in other industries – for instance the low pay rate in this occupational group in hotels is more than 90% (cf. ibid.). However, the incidence of low wage work is higher in the German health sector than in the French one, where only 10,5% of the nurse assistants and 16% of the cleaning staff earn less than the low wage threshold (€ 6 net hourly wage).

Table 2 : Incidence of low wage work in the German and French health sector (2002)

| | Germany* | France** |
|---------------------------------|----------|----------|
| Health (85) | 21,6 | 10 |
| Hospitals (85A) | | 4,9 |
| NA in health sector) | 22,5 | 10,5 |
| NA (hospitals) | | 2,4 |
| Cleaning staff in health sector | 42,6 | 16 |
| Total (whole economy) | 16,6 | 11,1 |

*Germany: calculation basis: full time employees, gross wages (Source: Beschäftigtenstatistik, calculations: T. Kalina, IAT)

** France: calculation basis: full time employees, net wages, only private for profit organizations (Source: DADS). As seen before, the average wages are roughly 11% below the public sector. So, in the public sector, only the first entry wage level could be said as being low wage. Public hospitals could be described as being without low wage work (excluding the employees on public subsidized schemes, see below).

A comparison between the two countries has to consider that these calculations are based on distinct groups and definitions (net/gross wage; public/private sector, see above) and therefore data are not directly comparable. However, the data point at a higher wage compression at the bottom of the wage band in France, i.e. wages for those employed in the low skill occupations under study do not seem to deviate from employees in other occupations and industries as strongly as in Germany. Yet that does not necessarily mean that the wage compression is higher *within* hospitals: The difference between the collectively agreed wages of nursing assistants and nurses is much higher in France than in Germany (see table 1).

Given that the data are incomplete and need further adjustments in order to allow for proper comparison, we are not able, at this point in time, to conclude on how big the differences in the wage structures are. Therefore in the following we will only enumerate some factors that might explain possible differences in the wage structures and hence the different degree of low wage work in the two countries – whatever the differences may look like. An assessment of the importance of these factors remains a central objective of the empirical study.

The different wage structures could be due, on the one hand, to a different structure of employment. As a matter of fact, the share of nursing staff is different in the two countries (40% in Germany, 50% in France) and within the nursing staff, the share of registered nurses is higher in Germany than in France: There is 1 nursing assistant per nurse in France, compared to 1 nursing assistant per 8 nurses in Germany. At this step of our work we need to do deeper investigations about the division of labour, the building of occupational categories, the training policies. There is some evidence that we cannot base the comparison on a simple equivalence between the statistical categories.

On the second hand the pressures on low wage work seem to be higher in Germany. The French SMIC is just below the low wage threshold and plays up to day a strong regulating role. Due to the weight of seniority rules, in the French hospitals (public and private for profit), only the new recruits will be paid at the SMIC level. The French hospitals sector remains a sector protected from wage cuts and low wage strategies, whereas this is no longer the case in Germany. Here, the public regulations on the financing of health care that previously worked in favour of relatively uniform and high wages has been altered and the traditional institutions characterizing the ‘German Model’ have not proved to offer long term protection, but only have contributed to a modification of the *pace* of change. This becomes obvious when comparing hospitals with different ownership and hence with a different degree

of ‘embeddedness’ in the institutions of the ‘German Model’: The church hospitals were able to lower wages *within* their institutional framework on collective agreements, mainly due to weaker traditions and rules for collective bargaining, whereas private for profit hospitals have escaped the former collective agreements and re-entered the system of collective bargaining only on a decentralized basis. In the remaining public hospitals, the wages decreased through two consecutive steps: changes were first made through a bypassing of the collective agreements, mainly through outsourcing, but the ‘race to the bottom’ in the other parts of the sector and the ongoing financial restraints imposed by the new financing system have finally led to an adjustment within the traditionally highly centralized collective bargaining system, albeit with more opportunities for decentralized collective bargaining as well.

3.2 What prospects for the SER? The proliferation of ‘atypical’ employment

In the literature on ‘atypical’ employment there is a broad variety of meanings associated with the term, encompassing a broader or narrower set of types of employment. Instead of engaging in a discussion about what kind of employment deserves to be termed ‘atypical’, we will concentrate on two core aspects that are often discussed under this heading: 1) employment stability and 2) working time. As we will see, an investigation of these aspects does not only amplify the perspective by including further dimensions of the quality of work, but also contributes to a better understanding of the pace of change and the full extent of changes with respect to wages. The differences in the employment stability in French and German hospitals for example may prove to be an important intermediate factor influencing the proliferation of low wages. The developments concerning working time volume, on the other hand, shed additional light on the question whether people earning low hourly wages are able to make a living with their earnings.

3.2.1 Employment stability

Whereas the legal and collectively agreed provisions that influence the employment stability are similar in the French and German public sector, differences concern the share of employees still falling under these provisions. Although there is incidence of bypassing these provisions in both countries, the trend seems to be stronger in Germany than in France, due to a more pronounced trend towards subcontracting (see section 1).

In the French public sector, the “civil servant status” remains the law. The vast majority of the staff has the status of civil servant: recruitment done after professional interviews (in the case of external recruitments) or through “aptitude” lists (for internal mobility). In 1998, non-civil servant employees represented 11% of the labour force (excluding subsidised employment) but almost 70% of those employees were members of the medical staff. In 2002, the rate of civil servants was 87% for NA and 80% for ASH (DHOS, 2004, Budet, 2004). This rate fluctuates according to the number of recruitment of contractors or trainees and according to the rate at which tenure is awarded. Part of the non-civil servant employees are recruited for part-time jobs so as meet the needs for labour created by part time employment among civil servants. In theory the direct recruitment of a civil servant for part time work is not allowed, but it was used in our first case study. However we note that a number of employees “prefer” to be recruited under a fixed or non-fixed term contract for salary-related reasons (the wages offered under fixed or non fixed term contracts are not necessarily the lowest) and /or in view of integrating the civil service later on.

But the bypassing of institutional rules is twofold :

- a) Firstly, public hospitals are able and constraint (due to administrative and political pressure) to hire unemployed people through public specific schemes. Those

(usually low skilled) people are on short term contracts, part time (50% or 75%) and paid at the SMIC level. Officially, these contracts must be additional ones (not to replace ordinary staff). But in fact, they are used as a flexible tool, in order to both decrease the wage cost and to adjust the level of the employment. In our first case study, more than 100 contracts of this type were recorded, for the cleaning staff, a part of which will be transformed into permanent contract and, later into civil servant recruitment. If taken into account, it will increase the incidence of low wage work

- b) Secondly public hospitals could hire staff on fixed term private contracts. Up today, it is more used for the medical staff than for the unskilled or semi-skilled staff. A very recent law (mid 2005) is enlarging the possibility of private (fixed term or not) contracts for the whole public sector. Unions are fighting against. In the hospitals with a high degree of unionisation, they will probably be able, as in the past, to restrict this possibility.

In Germany, employees of public hospitals in our target occupations are not civil servants, but the collective agreement provides a similar status after 14 years of employment. After this employers are not allowed to dismiss employees; this clause has been retained in the new collective agreement.

Accordingly, in the public hospital first visited seniority among cleaners and ward assistants is very high. More than 50% of its the cleaning staff directly employed by the hospital were employed for more than 20 years, only 11% were employed for less than 10 years. Yet paradoxically this high seniority is already a result of the bypassing strategies of the hospital in order to circumvent the provisions of the public service sector collective agreement: The hospital stopped recruiting its own cleaning staff more than 5 years ago and instead increasingly transfers the cleaning to an external service company whose employees replace the own cleaning staff step by step. The works council of the hospitals opposes this process of a ‘creeping privatization’, but has only very limited legal possibilities to prevent it, since codetermination rights concerning temporary work and outsourcing contains a number of loopholes. Hence, similar to the development in church owned hospitals, it is not the institutional environment that has changed, but rather the exploitation of options provided by the institutions even previous to the increase of financial pressures.

The result are two separate ‘worlds’ of employment conditions, both in terms of wages (see above) and in terms of employment stability: labour turnover in the private cleaning industry tends to be highly above average (see Hieming et al. 2005), which is due, among other factors, to a rather weak effective dismissal protection by lack of strong works councils in this industry. The weak dismissal protection and high labour turnover probably also facilitates the enforcement of ever increasing work loads that have risen dramatically over the last two decades, following the outsourcing of cleaning services in all parts of the economy (see Mayer-Ahuja 2003). In the first case study hospital, the two worlds of employment conditions coexist even within the organization through an outsourcing of only a part of the cleaning activities. In this case, the interviewed persons unanimously confirmed that the employees of the external service company clean the patients rooms at a considerably higher speed than the own cleaning staff of the hospital and that this also exerts pressures towards an increase in works loads for the own cleaning staff. Hence, in the long run the existence of two distinct worlds of employment conditions also affects the employment conditions of those who remain under the protection of the ‘old’ institutional framework.

3.2.1 Working time regulation and part time

In both countries, two trends must be considered:

a) The trends concerning the weekly and yearly working time of full-time employees

In this respect, the current course of changes points in opposite directions. In France, due to the 35 hours (legal) regulation, the yearly and weekly working time has been reduced, in 2001 for the private sector, in 2002 for the public one (Segrestin, Tonneau, 2001). The yearly working time according to the new law is slightly below 1600 hours (due to specific regulations linked to the shift work). In the first case study (a public hospital), it ranges between 1538h and 1568h according to the shift's organisation and to the occupations. The weekly working time can depend on specific agreements: whether the choice is a 35 hours week organisation (without days of time off) or whether the choice is a longer working time but with days of time off. This short and highly regulated working time is attractive, compared to other activities. It is also a factor of convergence between public and private hospitals (in private hospitals the effective working time is slightly lower for the full timers – defined as working more than 80% of the regular working time- but this difference could be due to the different structure within the -long- part timers).

In Germany the trend points rather in the opposite direction: Although the collectively agreed wages have constantly decreased until the mid-1990's and have remained stable since, this is not the case for the *effective* working hours: At least in West Germany effective working hours have increased since the mid-1990s (cf. Lehdorff 2003). Nevertheless, so far the effective working hours remain roughly the same as in France, where the gap between collectively agreed and effective working hours is obviously higher than in Germany: According to recent calculations, the effective yearly working time of full time employees in 2004 was at 1756 hours in Germany and 1747 hours in France (cf. Bosch/Schief/Schietinger 2005: 15). But in Germany the trend towards an increase of working time is currently gaining importance with employer's organisations (including some public service sector employers) succeeding in bargaining higher working hours for their employees (even without analogous wage increases). So far this only concerns the university hospitals that are owned by the federal states, whereas in the majority of public hospitals the collectively agreed weekly working time is still 38.5 hours. In the first case study, there was only very little incidence of overtime in the occupations under study, and in addition to that the few hours worked overtime were compensated for in time-off. A prolongation of the working time might however follow the introduction of the new collective agreement which contains an opening clause that leaves it to regional collective bargaining to decide on longer weekly working hours.

b) Increasing part time work: From voluntary to compulsory part-time?

In both countries, part time is increasing, both in the economy as a whole and in the occupations under study. The share of (female) part-time employment remains considerably higher in Germany, reflecting the legacy of the "male breadwinner" model that is deeply rooted in cultural notions of child care responsibilities (cf. Pfau-Effinger 2000) and is accompanied by less child care facilities (cf. Bosch 2004: 629). In France, part time is also expanding, but on a lower level.

Table 3: Incidence of part time in German and French hospitals

| | G 1991 | F 1991* | G 2002 | F 2001* |
|--------------|---------------|----------------|---------------|----------------|
| Nurse | 25% | 16% | 38% | 23% |
| NA | 35% | 11% | 48% | 21% |

| | | | | |
|-----------------------------|-----|--------|-----|--------|
| Jobs in housekeeping | 27% | 7,5 ** | 38% | 14% ** |
|-----------------------------|-----|--------|-----|--------|

* only for public hospitals

** ASH only, part time in administrative occupations is similar to NA

What we do not learn from the quantitative figures is whether the increasing number of part-time jobs have been taken up voluntarily or involuntarily by the employees. Secondly, additional information on the rules governing part-time is necessary in order to assess the quality of part-time jobs.

In France, chosen part time seems to be more the case for the nurses and the NA than for the cleaning staff (80% of the NA with part time are declaring not to want working more, only 66% of the ASH). In the first case study, cleaning staff is obliged to start with part time job and, later, to evolve from (short) part time to longer part-time and/or full time job. Since the 35 hours regulation, there is a convergence between part time and full time: the number of long part timer (more than 70% of the regular working time) is increasing, in all categories. A typical choice for a women with children could be to work 70 or 80%, i.e four days a week (8 hours shift), allowing a free Wednesday when schools are closed and some “time off days”, due to daily and/or Saturday Sunday overtime.

This part time organisation (with usually continuous working hours during a day) is very different to what is found in other services activities (higher level of part time, shorter duration, more “split working time”): it resembles a “full time regulation“ and seems to be reinforced in the recent years for the public hospitals. In the private for profit sector, incidence of part time is quite similar for NA and nurses, but higher for the ASH, which could indicate a higher level of compulsory part time for this category.

For Germany detailed data on the question of voluntary or compulsory part-time in hospitals where not at hand. Own research findings on ambulatory care services and the cleaning industry (cf. Hieming et al. 2005) point at a rising share of involuntary part-time in the occupations under study. This trend was probably reinforced through the new legislation on marginal part-time introduced in 2003 which has led to a strong increase of the so called ‘minijobs’ with very few weekly working hours. The private cleaning industry is among those industries with the highest share of minijobs (more than 50% in West Germany, cf. Hieming et al. 2005), therefore we will probably find a rather high share of (voluntary or involuntary) part-time among cleaners of external service companies in hospitals. But incidence of involuntary part-time is also to be found among those directly employed by hospitals. According to a member of the works council in the first public hospital visited, part-time work among cleaners nowadays is often involuntarily. Already during the nineties, when the hospital still recruited new employees, hospital management changed its strategy and only offered part-time jobs, with the aim to lower the absenteeism rate and to allow for greater temporal flexibility. This lead to the situation that women with children who had reduced their working hours temporarily (but longer than 3 years, within which they are by law granted the right to resume the full working hours which they had before parental leave) were not allowed to return to the full working hours they had before parental leave.

The quality of part time jobs particularly depends on whether they are minijobs or regular part-time jobs fully covered by social insurance. Apart from social insurance coverage, research on marginal part time employment has repeatedly found that further employment rights such as paid holiday leave is often ignored.

Hence, the rules and institutions that regulate part-time have so far primarily aimed at granting employees the right to work part-time and at guaranteeing them equal employment conditions as full-time employees – in French hospitals this objective seems to have been

implemented most successfully. In contrast the rules are not well adapted to the rather new phenomena of involuntary part-time. The question of involuntary part-time is of particular relevance for low wage occupations, for the obvious reason that in low wage part-time jobs, the low hourly wages accumulate to living wages even less.

4. Conclusion

At this step of our work, we are only able to underline key questions (to be investigated later), key trends and to formulate some hypothesis.

Among the key questions are the differences in the division of labour, in the level and structure of employment and their relationship with the wage structure (including the apparently higher incidence of low wage work in German hospitals, even before the deregulation process). All this questions are very typical of the German/French “societal analysis”, that was initially born out of a comparison of wage hierarchies in French and German firms (cf. Maurice Sellier Silvestre, 1982, Vassy, 1999, Maurice, Sorge 2000). Deeper investigations about the social building of the occupational categories and the division of labour are needed. About the incidence of low wage work, we must check if, despite the common international definition (two third of the median wages) there is no statistical artefact (due for example to the gross/net wage). We must also clarify the differences between the health sector in a whole and the hospitals' sub sector. Last, but not least, the different share and organisation of part time could introduce differences in the hourly wages if the wage regulation of the part timers is far away from the full timers' wage regulation.

The key trends concerning the employment relationship could be summarized as in the following table:

Table 4 : Main trends in the employment relationship in hospitals

| | Germany | France |
|---|--|---|
| Institutional rule | Centralised collective bargaining | Public statutory rules + collective bargaining |
| Role of the public sector | Eroding (but never as predominant as in France) | Still dominant |
| Political main pressure | Wage deregulation | Specific (non public servant) contracts, including specific wage levels |
| Trends | Decentralisation (regional and firm level) | Still centralised |
| Firms' behaviors | Trying to escape the institutional framework (private for profit), or adjustment within (others) | Using opportunities at the margins of the institutional framework (public schemes) |
| Wage trend | Race to the bottom, downward homogenisation between the three sub sectors | Still stable, upward homogenisation between private for profit and public sector |
| Employment status and protection | High (public sector employees) versus low (employees in external service companies) employment stability | Very high (public sector), higher than in other economic sectors (private for profit) |
| Role of part time | Declining share of 'regular' part-time jobs included in the SER | Included in the SER |

If we come back to the initial question of the eroding process of the SER, firstly, it must be underlined that the global pressures exerted on hospitals are very similar in the two countries (including the “flat rate financing process”, but this reform was implemented earlier in Germany, which could partly explain the different paces of the change).

Secondly, it has become obvious that we must take into account the various dimensions of the SER and not only the wage component. In both countries, trends are very different according to these dimensions. If, in Germany, the deregulation process is developing and concerns mainly the wage levels of the new recruits, the other dimensions of the SER in hospitals seems to be more stable (seniority rules, employment protection), albeit only for those still directly employed by the hospitals. In the French public hospitals, and up to today, we found some indicators of by passing the institutional framework, but the overall conclusion would be a more stable SER (on all its dimensions) than in Germany.

For an explanation of the different pace and result of change we want to come up with the following hypotheses:

The higher level of centralisation of the wage regulation, in France, due on the one hand to the SMIC regulation and on the other hand to the civil servant status. Changing these rules implies a global and national reform, which could affect not only some sectors but the whole economy and the whole public sector. It will need a very strong political pressure and governmental willpower which, despite the political official discourse, was not evident up today. And, within the public sector, the political fear of the big national strike of the mid 1990's remains high.

This different degrees of centralisation of the institutional framework goes hand in hand with the different structure of the hospitals sector. In the field of the classical medical care, the public French sector has the lion share. The for profit sector is a “second rank” actor, acting in specific niches. If the private non for profit sector (that we had no time to examine in this paper) looks like more to the German one (more decentralised and numerous collective agreements, apparent trend to an increasing wage gap with the public sector in the recent years), it is also a minor actor in the field of classical medical care (less than xx) and is more involved in psychiatric activities, long term care facilities and some highly specialised medical care (cancer for example) but with a close association with public sector which, in this specific case does not allow very different rules. So the strength of the French public sector, with its centralised institutional framework could also partly explain not only the relative stability of the SER but also the internal dynamic of the other sub sectors, obliged to compete with it on the labour market.

Within this framework, unions' strategies and opportunities are very different. In Germany, they failed to avoid the subcontracting and outsourcing process for the lowest categories, not only in church owned or in privatized hospitals but also in the remaining public hospitals, which is partly due to loopholes in the codetermination law. Today there is an apparent change in their strategies: bargaining new collective agreements with lower wages for the beginners, in exchange of the re-integration of the external labour force in the collective agreements and of the stability of the other dimensions of the SER. In France, despite the lower rate of unionisation, the unions in the hospital public sector were still able to fight against the outsourcing and subcontracting process. If they made concessions on the bypassing process for the public schemes, it was also on the name of the fight against unemployment and of the solidarity between workers. But they always watched to the later integration of a part of these workers in the public civil servant labour force. But again, this is also partly due to the common institutional framework with the overall public sector.

To sum up, we have found evidence of different pace and result of changes in the employment relationship in the two countries, although the external (para-)economic pressures can be considered as roughly the same. Can institutional differences contribute to an explanation of these different reactions? Looking at our results so far, the answer has to be: yes and no. First of all, what became obvious is that the major changes have not been triggered by active deregulation from the part of the legislator but by an increasing ability and willingness on the part of the employers to exploit loopholes in the legislation that already existed previous to rising economic pressures – as for example the possibility to unilaterally impose working conditions in German church owned hospitals or the possibility to subcontract. A possible explanation would be that the French legislation provides less loopholes, this remains to be investigated more closely; in that case the answer would be a 'yes'. But it seems to be at least as important that the ability and willingness to make use of these loopholes is obviously less pronounced in the French case, something that can be concluded from the less extensive use of subcontracting for cleaning services. But a thorough explanation of the different dynamics can not stop here: How could this different ability and/or willingness to exploit loopholes be explained? One important factor is probably the different industrial structure, with a traditionally higher importance of private (non for profit) hospitals in Germany, whose deregulating process finally exerted a downward pressure also on the remaining public hospitals. But it might also be due to a different ability and/or willingness of unions to oppose deregulation processes by mobilizing the employees. If it is true that deregulation take place, to an important extent, via a bypassing of the core institutions of the respective national model of employment, the importance of this ability to mobilize might have gained importance compared to previous times.

To go further on these very first hypothesis, it will be necessary to have a deeper comparison between the two countries within the hospital sector, but also, if possible, between the hospital sector (with its specific structure and regulations) and other sectors (such as the cleaning sector).

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